Developing Health Plan Performance Standards for Serving People with Disabilities in Medi-Cal: Summary of Recommendations

Center for Disabilities Issues and the Health Professions

Center for Health Care Strategies

The Lewin Group

November 21 & 22, 2005

Project Support

- California HealthCare Foundation
- California Department of Health Services

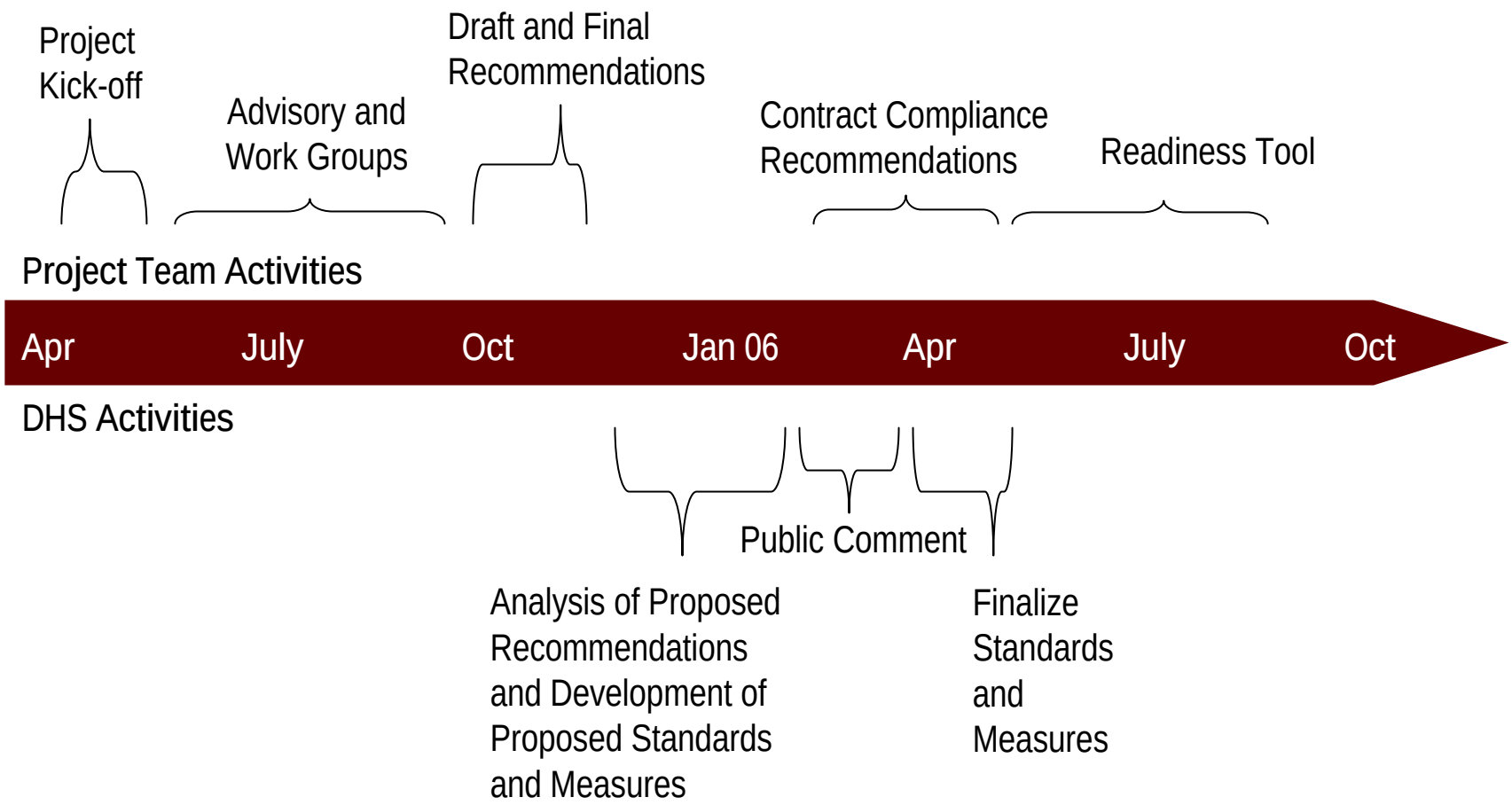
Project Goal

To *enhance* California's Medi-Cal managed care program to support a health care *delivery system* that provides *quality care* for persons with disabilities and chronic conditions.

Project Objectives

- Develop Medicaid managed care performance standards and measures to foster improvements in quality of care for people with disabilities and chronic illness
- Develop recommendations for how DHS and other departments within CHHSA can support improvements in quality of care for this population
- Develop recommendations for monitoring contract compliance
- Develop a tool to assess health plan readiness

Timeline

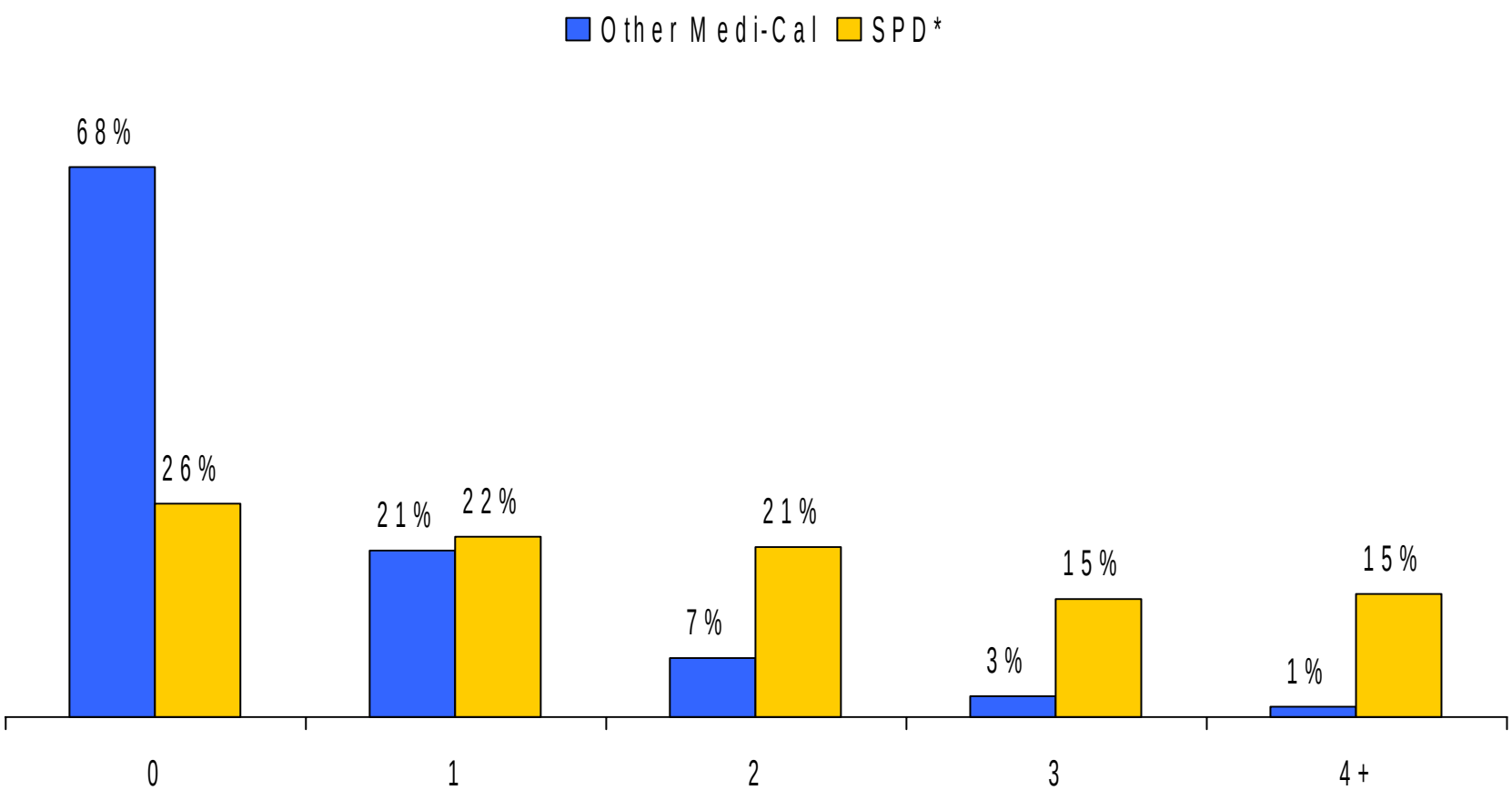

Project Kick-off
Advisory and Work Groups
Draft and Final Recommendations
Contract Compliance Recommendations
Readiness Tool
Project Team Activities
Apr
July
Oct
Jan 06
Apr
July
Oct
DHS Activities
Public Comment
Analysis of Proposed Recommendations and Development of Proposed Standards and Measures
Finalize Standards and Measures

Populations and Services Covered

For the purposes of this project, we focused on:

- Adults (22-64) with disabilities and chronic conditions
- Children as they related to non-CCS services, transition, and care coordination
- Seniors as they related to care coordination and transition issues
- Acute care services provided under Medicaid managed care

Prevalence of Multiple Conditions



Source: The Lewin Group for CHCF. Analysis of 20% sample of Medi-Cal fee-for-service claims data, FY2001.
Note: Beneficiaries with Medicare coverage (dual-eligible) are excluded.
* Among Medi-Cal-only SPD population, approximately 80% are under age 65.

Project Methodology & Activities

- Reviewed current governing documents (e.g., Medi-Cal managed care contract, CA Code)
- Conducted research on best practices in other states' Medicaid managed care programs
- Convened workgroups and Advisory Group to identify and discuss current practice, options, pros and cons
- Drafted recommendations and solicited feedback from local and national parties
- Developed final recommendations

Workgroup Topics

- Accessibility
- Provider Network
- Enrollment and Member Services
- Benefit Management
- Care Management
- Coordination of Carve-out and “Linked” Services
- Quality Improvement
- Performance Measurement

Guiding Principles Used to Develop Recommendations

- Create a paradigm shift or systems view toward delivering quality health care to people with disabilities and chronic conditions
- Provide equality of opportunity to managed health care services
- Promote a consumer/patient/family-centered approach to care delivery
- Emphasize the importance of maintaining and improving functional status, quality of life, and wellness

Guiding Principles Used to Develop Recommendations

- Build the knowledge and understanding of health care professionals regarding the complex and multi-faceted needs of people with disabilities
- Create a flexible care model that can adapt to the different needs of people with disabilities and chronic condition
- Use public resources more effectively
- Build accountability into the health care system at the state, plan, provider, and consumer level

State Ingredients for Success

- Conduct pre-implementation activities
- Analyze data to understand the member population
- Ensure continuity of care during transition
- Define system of care state wants to create and purchase
- Balance expectations with adequacy of rates

State Ingredients for Success

- Make current carve-out system easier to navigate
- Recognize and provide the state resources necessary to build infrastructure (e.g. enrollment broker, EQRO, state staff)
- Publicly report on performance of both the FFS and managed care
- Involve stakeholders during development and implementation

Cross-Cutting Issues

MCO Recommendation

- Conduct MCO disability and competency training for providers
- Conduct early identification of health and accommodation needs
- Engage in meaningful consumer participation

State Action

- Develop statewide education plan for providers
- Develop initial screen for new members
- Provide MCOs with member specific, historical FFS data (aggregate and member-level)

Enrollment & Member Services

MCO Recommendation

- Ensure smooth transition from FFS to MC (e.g., ongoing treatment is not interrupted, # medical records are transferred)
- Facilitate member advocacy for members with disabilities
- Provide member services guide in alternative formats within seven days and other material upon request

Quality Improvement

MCO Recommendation

- Identify and stratify members with disabilities and multiple chronic conditions
- Collect and stratify utilization indicators
- Conduct statewide QIP on issue related to people with disabilities and chronic conditions

State Action

- Provide MCO with stratified data of its population
- Select QIP on issue related to people with disabilities and chronic conditions
- Facilitate QIP to improve coordination of care among MCOs and carved-out services

Accessibility & Provider Network

MCO Recommendation

- Measure and disclose accessibility of provider sites (through FSR, provider directory, and Web site)
- File Annual ADA Accessibility plan with CDHS
- Expand definition of accessibility
- Enhance definition of medical home (specialists as PCPs, etc.)

State Action

- Review accessibility policies and procedures as part of periodic MCO compliance audit
- Use community standards of care to assess exemptions from time and distance standards

Benefit Management

MCO Recommendation

- Clarify criteria used to make review decisions for new technology and investigational treatment revised
- Use qualified physicians with appropriate expertise review all service denials
- Arrange for specialty services provided out-of-network when medically necessary

State Action

- Review medical necessity definition to reflect maintenance of function

Care Management

MCO Recommendation

- Combine case management and care coordination into integrative care management plan
- Identify members who need care management
- Develop individual care plans
- Assist members in coordinating out-of-plan services

State Action

- Establish work group to evaluate innovative practices in care management

Performance Measurement

MCO Recommendation

- Stratify existing EAS measures
- Collect additional HEDIS measures

State Action

- Use MMCD QI Committee to identify non-HEDIS measures to pilot test
- Enhance statewide consumer satisfaction survey

Coordination of “Carved-Out” Services

State Action

- Develop and comply with statewide MOU for all CHHSA departments and report annually on compliance and improvement (legislative requirement)
- Clarify appropriate payer when primary payer is unclear
- Develop local level MOU to ensure coordination across carved-out services and health plans

Next Steps

- Report can be downloaded from the CHCF Web site at www.chcf.org
- Over the next several months, project team develops:
  - Health plan readiness assessment tool
  - Recommendations for monitoring contract compliance
- DHS review and public comment period (winter and spring)